

SEP 13 2010

PTO/SB/85 (09-09)

Approved for use through 03/31/2012. OMB 0651-0018

U.S. Patent and Trademark Office, U.S. DEPARTMENT OF COMMERCE

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**PETITION TO ACCEPT UNAVOIDABLY DELAYED PAYMENT OF
MAINTENANCE FEE IN AN EXPIRED PATENT (37 CFR 1.378(b))**

Docket Number (Optional)

Mail to: Mail Stop Petition
Commissioner for Patents
P.O. Box 1450
Alexandria VA 22313-1450
Fax: (571) 273-8300

NOTE: If information or assistance is needed in completing this form, please contact Patents Information at
(571) 272-3282.

Patent Number: 6989740Application Number: 10/073236Issue Date: 01/24/2008Filing Date: 02/13/2002

CAUTION: Maintenance fee (and surcharge, if any) payment must correctly identify: (1) the patent number (or reissue patent number, if a reissue) and (2) the application number of the actual U.S. application (or reissue application) leading to issuance of that patent to ensure the fee(s) is/are associated with the correct patent. 37 CFR 1.366(c) and (d).

Also complete the following information, if applicable:

The above-identified patent.

☐ Is a reissue of original Patent No. _____ original issue date _____

original application number _____

original filing date _____

☐ resulted from the entry into the U.S. under 35 U.S.C. 371 of international application
_____ filed on _____

CERTIFICATE OF MAILING OR TRANSMISSION (37 CFR 1.8(a))

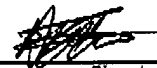
I hereby certify that this paper (along with any paper referred to as being attached or enclosed) is

(1) being deposited with the United States Postal Service on the date shown below with sufficient postage as first class mail in an envelope addressed to Mail Stop Petition, Commissioner for Patents, P.O. Box 1450, Alexandria, VA 22313-1450 OR

(2) transmitted by facsimile on the date shown below to the United States Patent and Trademark Office at (571) 273-8300.

09/11/2010

Date



Signature

JOSEPH AKWO TABE

Typed or printed name of person signing Certificate

(Page 1 of 4)

This collection of information is required by 37 CFR 1.378(b). The information is required to obtain or retain a benefit by the public which is to file (and by the USPTO to process) an application. Confidentiality is governed by 35 U.S.C. 122 and 37 CFR 1.11 and 1.14. This collection is estimated to take 8 hours to complete, including gathering, preparing, and submitting the completed application form to the USPTO. Time will vary depending upon the individual case. Any comments on the amount of time you require to complete this form and/or suggestions for reducing this burden, should be sent to the Chief Information Officer, U.S. Patent and Trademark Office, U.S. Department of Commerce, P.O. Box 1450, Alexandria, VA 22313-1450. DO NOT SEND FEES OR COMPLETED FORMS TO THIS ADDRESS. SEND TO: Mail Stop Petition, Commissioner for Patents, P.O. Box 1450, Alexandria, VA 22313-1450.

If you need assistance in completing the form, call 1-800-PTO-9199 and extension 2.

01 FC:1599 1005.00 OP

Sunday, September 12, 2010 8:24 PM

JOSEPH TABE 301 622 1810

p.05

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PTO/SB/65 (03-08)

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1. SMALL ENTITY

☒ Patentee claims, or has previously claimed, small entity status. See 37 CFR 1.27

2. LOSS OF ENTITLEMENT TO SMALL ENTITY STATUS

☐ Patentee is no longer entitled to small entity status. See 37 CFR 1.27(g)

3. MAINTENANCE FEE (37 CFR 1.20(e)-(g))

The appropriate maintenance fee must be submitted with this petition, unless it was paid earlier.

NOT Small Entity			Small Entity		
Amount	Fee	(Code)	Amount	Fee	(Code)
<input checked="" type="checkbox"/> \$ _____	3 ½ yr fee	(1551)	<input checked="" type="checkbox"/> \$ 490	3 ½ yr fee	(2551)
<input type="checkbox"/> \$ _____	7 ½ yr fee	(1552)	<input type="checkbox"/> \$ _____	7 ½ yr fee	(2552)
<input type="checkbox"/> \$ _____	11 ½ yr fee	(1553)	<input type="checkbox"/> \$ _____	11 ½ yr fee	(2553)

MAINTENANCE FEE BEING SUBMITTED \$ _____

4. SURCHARGE

The surcharge required by 37 CFR 1.20(l)(1) of \$ 600 (Fee Code 1557) must be paid as a condition of accepting unavoidably delayed payment of the maintenance fee.

SURCHARGE FEE BEING SUBMITTED \$ 600

5. MANNER OF PAYMENT

☐ Enclosed is a check for the sum of \$ _____☐ Please charge Deposit Account No. _____ the sum of \$ _____☒ Payment by credit card. Form PTO-2038 is attached.

6. AUTHORIZATION TO CHARGE ANY FEE DEFICIENCY

☐ The Director is hereby authorized to charge any maintenance fee, surcharge or petition fee deficiency to Deposit Account No. _____

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37 CFR 1.378(d) states: "Any petition under this section must be signed by an attorney or agent registered to practice before the Patent and Trademark Office, or by the patentee, the assignee, or other party in interest."



Signature

09/11/2010

Date

JOSEPH AKWO TABE

Type or printed name

Registration Number, if applicable

STATEMENT

(In the space below, please provide the showing of unavoidable delay recited in paragraph 8 above.)

My wife was pregnant and had some complications which needed medical attentions.

(Please attach additional sheets if additional space is needed)

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7. OVERPAYMENT

As to any overpayment made, please

☐

Credit to Deposit Account No. _____

OR

☒

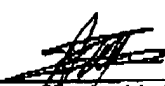
Send refund check

WARNING:

Petitioner/applicant is cautioned to avoid submitting personal information in documents filed in a patent application that may contribute to identity theft. Personal information such as social security numbers, bank account numbers, or credit card numbers (other than a check or credit card authorization form PTO-2038 submitted for payment purposes) is never required by the USPTO to support a petition or an application. If this type of personal information is included in documents submitted to the USPTO, petitioners/applicants should consider redacting such personal information from the documents before submitting them to the USPTO. Petitioner/applicant is advised that the record of a patent application is available to the public after publication of the application (unless a non-publication request in compliance with 37 CFR 1.213(e) is made in the application) or issuance of a patent. Furthermore, the record from an abandoned application may also be available to the public if the application is referenced in a published application or an issued patent (see 37 CFR 1.14). Checks and credit card authorization forms PTO-2038 submitted for payment purposes are not retained in the application file and therefore are not publicly available.

8. SHOWING

The enclosed statement will show that the delay in timely payment of the maintenance fee was unavoidable since reasonable care was taken to ensure that the maintenance fee would be paid timely and that this petition is being filed promptly after the patentee was notified of, or otherwise became aware of, the expiration of the patent. The statement must enumerate the steps taken to ensure timely payment of the maintenance fee, the date and the manner in which the patentee became aware of the expiration of the patent, and the steps taken to file the petition promptly.

9. PETITIONER(S) REQUESTS THAT THE DELAYED PAYMENT OF THE MAINTENANCE FEE BE ACCEPTED AND THE PATENT REINSTATED.
Signature(s) of Petitioner(s)

09/11/2010

Date

JOSEPH AKWO TABE

Typed or printed name(s)

Registration Number, if applicable

11700 OLD COLUMBIA PIKE, SUITE 2010

Address

240-462-0487

Telephone Number

SILVER SPRING, M.D 20904

Address

ENCLOSURES:☒

Maintenance Fee Payment

☒

Statement why maintenance fee was not paid timely

☒

Surcharge under 37 CFR 1.20(i)(1) (fee for filing the maintenance fee petition)

☒

Other:

SUPPORTING DOCUMENTS

SEP 13 2010

FUNCTIONAL ASSESSMENT						
Self Care	Walking	<input type="checkbox"/> Independent	<input type="checkbox"/> Uses a device	<input type="checkbox"/> Help of Another	<input type="checkbox"/> Totally Dependent	
	Stairs	<input type="checkbox"/> Independent	<input type="checkbox"/> Uses a device	<input type="checkbox"/> Help of Another	<input type="checkbox"/> Totally Dependent	
	Eating	<input type="checkbox"/> Independent	<input type="checkbox"/> Uses a device	<input type="checkbox"/> Help of Another	<input type="checkbox"/> Totally Dependent	
	Bathing/Dressing	<input type="checkbox"/> Independent	<input type="checkbox"/> Uses a device	<input type="checkbox"/> Help of Another	<input type="checkbox"/> Totally Dependent	
	Bowel/Bladder	<input type="checkbox"/> Independent/continent	<input type="checkbox"/> Home with help			
Assistive Devices/lines sent with patient <input type="checkbox"/> None <input type="checkbox"/>						
Communication	Language	<input type="checkbox"/> English	<input type="checkbox"/> Spanish	<input type="checkbox"/> Other:	Devices	<input type="checkbox"/> None <input type="checkbox"/> Glasses/Contacts <input type="checkbox"/> Hearing Aids
Translator				<input type="checkbox"/> Other:		
LOC/Orientation	<input type="checkbox"/> Alert <input type="checkbox"/> Oriented to person, place, time, event <input type="checkbox"/> Other:					
Condition at Discharge	T _____ P _____ R _____ BP _____ <input type="checkbox"/> Stable <input type="checkbox"/> Other:					
Allergies	<input type="checkbox"/> NKA <input type="checkbox"/> Other:					
Rhgam	<input type="checkbox"/> N/A <input type="checkbox"/> Given	Mother's blood type _____		Baby's blood type _____		Rubella <input type="checkbox"/> Immune <input type="checkbox"/> Vaccine Given <input type="checkbox"/> Vaccine Refused
DISCHARGE						
Call Doctor if you have:	1. Bleeding that soaks a pad in less than 1 hour 2. Bleeding mixed with clots the size of an egg or larger 3. Chills, fever over 100.4 4. Severe abdominal pain 5. Burning or frequent urination 6. Red streaks or pain in the breasts			7. Red streaks or pain in legs 8. Drainage from incision 9. Hot, swollen, painful stitches 10. Foul smelling vaginal discharge 11. Trouble coping with the "Baby Blues"		
Other Instructions						
Medications	Name of Medication	Purpose	When to take	Amount	Special Instructions	Prescription Given
					<input type="checkbox"/> FDI	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> FDI	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> FDI	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> FDI	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diet	<input type="checkbox"/> Diet as tolerated <input type="checkbox"/> Increase fluids <input type="checkbox"/> Continue Prenatal vitamins <input type="checkbox"/> Other:					
Activity	<input type="checkbox"/> No Limits <input type="checkbox"/> Don't climb stairs <input type="checkbox"/> No heavy lifting <input type="checkbox"/> Avoid driving <input type="checkbox"/> No sexual activity until after MD appt. <input type="checkbox"/> Other:					
Follow-up as Indicated	Washington Adventist Hospital Social Services Department 301-891-6465 Other Agencies:					
Follow-up Appointments	Name _____ call _____ for appointment in _____ Name _____ call _____ for appointment in _____ Name _____ call _____ for appointment in _____					
Discharge	<input type="checkbox"/> Home <input type="checkbox"/> Other:			Via <input type="checkbox"/> Wheelchair <input type="checkbox"/> Other:		
I have been taught, understand, and received a copy of these DISCHARGE INSTRUCTIONS				Nurse Signature, Date		
Patient's/Family Signature						
Hospital Phone Numbers: Unit 3100 Post Partum 301-891-6400 Newborn Nursery 301-891-6406 Lactation Consultant 301-891-6207						



Obstetric Discharge

WAH 640-107 Rev. 4/99

Patient Identification

ASHU, SUSAN
12044999
Dr: OBSTETRICS, OBW
Admit 02/11/10 F 30 11/16/79
MR # 0837134 WAH 3100

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BABY CARE INFORMATION		DATE & INITIALS TEACHING CODES		BABY CARE INFORMATION		DATE & INITIALS TEACHING CODES	
Watch Newborn Channel for Baby Care				Normal in newborn			
Handwashing	Viruses and bacteria are transmitted by hands. Wash frequently.			Hiccups			
Infant Safety In Hospital	Never leave baby out of line of sight, or give baby to unidentified staff, mother/baby bands.			Snoozing			
Orying as Communication	May be hungry, need to pass gas or burp, have diaper changed, be tired or want to be picked up. Never shake baby.			Skin Care	No oils or lotions on head, face or groin. Frequent changes and leave diaper open and exposed to air if rash.		
Positioning	Side or back. Not on stomach.			Diaper Rash			
Bulb Syringe - Choking	Use bulb to clear nose and mouth of secretions if choking. Keep it close.			Bath	Sponge or tub bath. No need to bathe more than every other day in first week of life.		
Stools	First stool (black-green) usually passed in 1-24 hrs. Then stools are greenish, then seedy soft yellow.			Soaps	Use mild soap. No perfumes.		
Urine	1st urine in 1-24 hrs. About 8-8 diapers after 48 hrs.			Nail Care	Use emery board (fine side). No cuticle scissors or nail clippers.		
Cord	Keep dry. Fold diaper below cord. Cord falls off 1-2 weeks.			Temperature Taking	Check temperature if you think baby is sick or otherwise instructed by your doctor. Use axilla (axilla). Normal 97.8° - 98.2°		
Diaper Change	Check every 2-3 hours if awake, and change if wet or dirty. Wash girls front to back.			Clothing	Infant retardant, comfortable. Do not overdress or wrap too tightly.		
Genitals - Girl	White or pink discharge or cheesy material normal in newborn.			Jaundice	A yellow color in skin and eyes common in 1st few days of life. Blood test (bilirubin) measures amount of yellow pigment.		
Circumcision Care	Apply petroleum jelly to tip of penis every diaper change for 2-3 days.			Environment	Smoke free, fire detectors. Avoid extremes of temp in house. No soft mattresses or pillows.		
Uncircumcised Care	No need to retract foreskin.			Car Seat	Follow manufacturer's directions for installation.		
Initials: _____ Signature: _____		Initials: _____ Signature: _____		Brest Feeding		Latching, positioning, frequency, length, brest feeding log, discussed.	
Teaching Method		Parent Taught		Teaching Outcome			
V = Verbal W = Written material D = Demonstration A = Audio Visual		P = Parent S = Significant Other T = Translator		VU = Verbal, understood RD = Return Demo			
SIGNS AND SYMPTOMS OF ILLNESS. CALL PEDIATRICIAN. • Redness, discharge or foul odor from eyes, circumcision or umbilical cord • Less than 4 wet diapers per day by 4 days old • Frequent, explosive, watery stools that soak through the diaper • Axillary temperature of less than 97.4° or greater than 100°F • Poor feeding, weak, sick, or no interest in eating • Vomiting forcefully several times, not just spitting up • Worsening jaundice • Turning blue or gray, or stops breathing • Excessive irritability or excessive sleepiness • Call 911 for any emergency with your baby.				INSTRUCTIONS <input type="checkbox"/> Second dose Hepatitis B Vaccine to be given in one month Schedule with Pediatrician <input type="checkbox"/> Second PRV in one month in 2-3 weeks <input type="checkbox"/> Bilirubin test in A.M. <input type="checkbox"/> at WAH lab <input type="checkbox"/> at Pediatrician Office FEEDINGS (type, amount, frequency)			
Medications		Name		Purpose		When to take	
<input type="checkbox"/> None						Amount	
						Special Instructions	
						<input type="checkbox"/> FDI	
						<input type="checkbox"/> FDI	
Follow-up Appointments		Name _____		call _____		for appointment in _____	
		Name _____		call _____		for appointment in _____	
Discharge		<input type="checkbox"/> Home with Car Seat <input type="checkbox"/> Other _____		Condition at Discharge			
		<input type="checkbox"/> Immunization Book given <input type="checkbox"/> Pediatrician Letter given					
I have been taught, understand, and received a copy of these DISCHARGE AND TEACHING INSTRUCTIONS				Nurse Signature, Date/Time: _____			
Mother's Signature _____							
Nursery: 301-881-5488				Maternity: 301-881-5400			
Lactation Consultant: 301-881-5887 (MOM)				Social Work Dept: 301-881-5445			



TEACHING AND DISCHARGE INSTRUCTIONS

Patient Label


 ASHU, BOY SUSAN
 12045176 Dr. STAFF PEDIATRICIAN, N

Admit: 02/12/10 M 0 02/12/10

MR # 0839515 WAH 3300

030-144 (Rev. 07/05)

WHITE: CHART COPY YELLOW: PARENT COPY

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Section 1: Physician (LIP) Discharge Instructions (complete for patients discharged to home / similar residence) If preprinted patient instructions are used or there is a dictated patient summary sheet for another facility, go to Section 4 and complete.

FOLLOW UP APPOINTMENTS - It is important for you to keep these appointments:

☒ Make appointment with Dr. PLATE Phone# 301 841 6600 In MON 3/1

☒ Make appointment with Dr. GB CLINIC Phone# 301 841 6647 In 2WK

☐ Contact Health & Wellness at 1-800-542-5096 for follow up community services, diabetes counseling, smoking cessation.

☐ Other appointments: _____

WHEN TO CALL YOUR DOCTOR - Call your doctor immediately if you have any of the following:

New or Worsening Symptoms:	Post-Procedure Symptoms:	Other Symptoms:
<input checked="" type="checkbox"/> Increased fatigue and weakness	<input checked="" type="checkbox"/> Fever more than 10.1	<input type="checkbox"/> Increased/decreased urination
<input checked="" type="checkbox"/> Shortness of breath/difficulty breathing at rest when lying down or with activity	<input checked="" type="checkbox"/> Increased tenderness/swelling/warmth at incision site	<input type="checkbox"/> Dry cough / wheezing
<input checked="" type="checkbox"/> Increased swelling of face, legs, abdomen	<input checked="" type="checkbox"/> Drainage/odor from incision site	<input type="checkbox"/> _____
<input checked="" type="checkbox"/> Weight gain 2.2 lbs in one day	<input checked="" type="checkbox"/> Bleeding from incision site	<input type="checkbox"/> _____
<input checked="" type="checkbox"/> Chest pain	<input checked="" type="checkbox"/> Increased/unexpected pain	<input type="checkbox"/> _____
	<input checked="" type="checkbox"/> Nausea/vomiting	

ACTIVITY

☐ Usual ☐ No stair climbing until _____ ☒ No heavy lifting until clear by clinic ☐ No driving until _____

☐ No walking until _____ ☒ No sexual activity until 6 wks ☐ No bathing/shower until _____

☐ Other: _____

DIET

☒ Regular ☐ Full liquid ☐ Clear liquid ☐ Soft ☐ Diabetic ADA _____ calories/day ☐ Other: _____

☐ Restrictive ☐ Salt _____ Gms/day ☐ Cholesterol _____ cups/day ☐ Alcohol ☐ Other: _____

☐ Tube Feeding _____ ☐ Supplement _____

TREATMENTS / PERSONAL CARE

Weigh and record your weight every day. If you have heart or kidney failure.

Stop smoking to speed cure. If you smoke, call for smoking cessation assistance: 1-800-542-5096

Additional Instructions:

Vaccinations Received in Hospital: ☐ Pneumovax DATE: _____ ☐ Influenza DATE: _____ ☐ Other: _____

Section 2: Additional Services (community resources/referrals and other arranged assistance)

Home Health: 301 841 5389 Phone# _____ Services: WOUND CARE Start Date: 1/26/10

Equip Co: _____ Phone# _____ Other: _____ Phone# _____

Section 3: Nursing Assessment/Summary (complete for all patients)

Reason for Discharge/Transfer: ☒ MD discharge order ☐ Expired ☐ AMA ☐ Transfer

Discharge to: ☐ Home ☐ Other Residence Transfer to: ☐ Non-Acute Facility ☐ Acute Facility ☐ Transfer/Discharge Summary & chart copied

Via: ☐ Walking ☒ Wheelchair ☐ Stretcher Made: ☐ Car/Van ☐ Ambulance ☐ By: ☐ Self ☐ Family/Friend ☐ _____

Valuables Sent: ☐ Denture: Upper ☐ Lower ☐ Glasses/Contacts ☐ Hearing Aid: Right Left ☐ _____

☐ Prosthesis (type): WHA Assist Device: ☐ Cane ☐ Walker ☐ _____ Isolation: ☐ Contact ☐ Droplet ☐ Airborne

Biopsychosocial Status: ☒ No change from last assessment ☐ Change from last assessment documented ☐ Airborne

Limitations: ☐ None ☐ Vision ☐ Communication ☐ Hearing ☐ Paralysis ☐ Amputation ☐ Other: _____

Self Care: (I=Independent; NA=Needs Assist; T=Total Assist) ☒ Walking ☒ Eating ☒ Dressing ☒ Bathing ☒ Elimination

Misc: ☒ Continent ☐ Incontinent Dates: Last BM: _____ Foley Insert: _____ IV/PICC Insert: _____ Other: _____

☐ Skin intact ☐ Skin not intact ☐ Incision ☐ Decubitus ☐ Abrasion Size: _____ Location: Abd mid & lower

(The transfer summary, progress notes, patient discharge medication reconciliation list & nursing and allied health records reflect the current biopsychosocial status (condition) of the patient & progress made toward goals)

☐ Patient ☐ Family / SO Instructed/verbalizing understanding: X Date: 02/25/10 ☐ N/A

Nurse providing instruction: Praveen Unit Phone# 5594 Discharge Date: 2/25/10 Time: 1530

Original for Chart / Copy for Patient or Receiving Facility



Discharge Instructions

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Page 1 Of 2

ASHU, SUSAN

Printed on: 02/25/10 09:10

02/19/2010 F 30Y
MR# 83713411/16/1979 2200
WAH

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PATIENT DISCHARGE RECONCILIATIONASHU, SUSAN
12046882

BED#: 2207-2

AGE: 30Y

MR#: 837134

SEX: F

HT: 5FT 9IN

UNIT: 2200

DOB: 11/16/1979

WT: 154LB 00Z

AS PREGNANCY; No Known Food Allergies

Reconciled Medications - Review medications; order as needed and discard sheet.

D5W/LACTATED RINGERS (D5W/LACTATED RINGERS)

VOL: 1000 ml @125 ml/hr 8 hrs

Route: Intravenously

Additional Instructions:

REASON:

Instructions

DEXTROSE 5% IN WATER (D5W)

VOL: 50 ml @100 ml/hr 0.50 hrs

CEFTRIAXONE (ROCEPHIN)

DOSE: 1 GM

Route: Intravenously

Additional Instructions: *REFRIGERATE*

REASON:

Instructions every 12 hours

DOCUSATE SODIUM (COLACE)

DOSE: 100 MG = 1 CAP

Route: By mouth

Additional Instructions:

REASON:

Instructions twice daily

ENOXAPARIN SODIUM (LOVENOX)

DOSE: 40 MG = 0.4 ML

Route: Subcutaneously - under the skin

Additional Instructions: POD#1 AT 0800 FOR 10 DAYS.

REASON:

Instructions daily at 9:00 am

FERROUS SULFATE (FERROUS SULFATE)

DOSE: 325 MG = 1 TAB

Route: By mouth

Additional Instructions: WITH MEALS TWICE A DAY

REASON:

Instructions MEALS

Reconciled Medications - Review medications; order as needed and discard sheet.

ACETAMINOPHEN (TYLENOL)

DOSE: 650 MG = 2 TAB

Route: By mouth

Additional Instructions: FEVER > 100.4

REASON: FEVER

Instructions every 4 hours as needed

OXYCODONE/APAP 5-325 (PERCOCET)

DOSE: 1 TAB = 1 TAB

Route: By mouth

Additional Instructions:

REASON: PAIN SCAL 2-5

Instructions every 4 hours as needed

OXYCODONE/APAP 5-325 (PERCOCET)

DOSE: 2 TAB = 2 TAB

Route: By mouth

Additional Instructions:

REASON: PAIN SCAL 6-10

Instructions every 4 hours as needed

**Washington
Adventist
Hospital**

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**DISCHARGE MEDICATION
RECONCILIATION**

(Page 1 Of 1)

For Reference Only

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11/16/1979 2200

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[illegible]

**Washington
Adventist
Hospital**

Original for Chart / Copy for Patient or Receiving Facility

Discharge Instructions

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